Group practice

PREFACE

Dr E. V. Kuenssberg, *C.B.E.*, M.B., Ch.B., F.R.C.G.P.

THIS conference was planned by the Practice Organization Committee of the Royal College of General Practitioners in order to gather together the experience and growing points developed by some of the exponents of group practice. During the preceding year, various chapters were allocated to working groups of two or three volunteers from the faculties. It is to their credit that such an immense volume of work was achieved in the short time available and its quality is clearly demonstrated in this report.

The objects of this conference were to present the facts about group practice and to stimulate discussion on its present state and future prospects. Background papers had been prepared for circulation before the meeting, and speakers introduced these briefly, leaving most of the time for contributions from the floor and general discussion.

Dr J. Struthers, one of the secretaries of the 'Gillie Report' chaired the conference with great success. The 25 faculties of the College each sent two delegates experienced or specially briefed on some aspect of group practice. Delegates from the Royal College of Nursing, the Royal College of Midwives, the Queen's Institute of District Nursing, the Royal College of Midwives, the Association of Health Visitors and the Association of Medical Officers of Health were most welcome and helpful participants. The omission of the experience and work with social workers in general practice is both serious and regrettable but it was not thought possible to tackle it within the framework of a tightly packed one-day conference.

No one will dispute that group practice is an important stage in the development of general medical services and this conference is offered as a contribution to the self-critical audit and analyses necessary if we are to make the most of this opportunity. The outstanding fact about group practice is that it is a team effort. No matter how many doctors, nursing sisters, health visitors or other people are involved, we cannot properly regard it as anything but a team. It is impossible to say who is more important; the person who has first contact with the patient by answering the telephone; the person who sits behind the reception desk, or some other member of the team. If patients could choose the door through which they would like to go, that of the nurse, the health visitor, or the doctor, it may be that the doctor's door would not be as busy as we as doctors would like to think. It is becoming more obvious that many patients, given the opportunity, select their doctors by his team.

When a large number of people work under one roof there are bound to be problems. With the help of an architect the design of the premises can be such that individual groups can work satisfactorily under one roof. There are communal rooms, records, drains, heating, toilets, etc. but the personal doctor is personal only for individuals and the message of this

conference is that the personal doctor, as far as it is practicable, is the basis for group practice.

To avoid repitition most of the points debated have been incorporated in the principal speakers' papers. Thus with the exception of Dr Reedy's paper these chapters are based on the contribution by the named speakers in combination with points raised in discussion. The aim of this editorial policy was to produce a more readable but less verbatim report.

It is realized that in due course this report will become outdated. It is hoped that the discussion of reasons for and experiments with practice organization will allow future developments to mature and that that flexibility which alone makes successful teamwork will be widened by the increasing experience and training of all members of the team.

We are indebted to all those who contributed to this conference and record our special thanks to Dr Peter Higgins who acted as secretary.

FOREWORD

(from a wheelchair-bound patient)

AFTER 30 years of struggle to maintain oneself at home, avoiding the repeated banishment to institutions, any change in routine is always viewed with faint misgiving when you no longer have the confidence that a healthy and co-ordinated body gives, but within a few weeks all doubts are completely dispelled. It is reassuring to find that you still have your own doctor, and in my sixties, I am still convinced that there is nothing finer than a good family doctor. Should he not be available, another partner comes to your aid, pleasantly and not at all reluctantly, he seems to have seen your case notes, even if you have not seen him before.

The fringe benefits are many—you have the help of an excellently well-trained nursing staff who don't change constantly, your team, and here a quite new relationship is built up, based on a kind of mutual trust and understanding, the result being that any little problem can be talked over and dealt with. This, plus coping with requests for prescriptions, can save time for the doctors. Yet through the nurses I feel that I am constantly in touch with my doctor. As a housebound patient, you are freshened up, skin cared for, dressed, tucked into your wheelchair, left feeling settled and comfortable and not weighed down with that feeling of tremendous obligation you have even with the best of relatives, and who among the disabled haven't wilted under the slightly pained look on the faces of the former when help is unwittingly asked for at an inopportune moment—Damned few! Within this framework you get a wonderful feeling of security—you know that whatever crops up you will be cared for, even to the point of getting you ready for hospital when necessary, and all this is done in the pleasantest manner possible.

The ultimate benefit of a service like this is that you are still a person, not a blot on the landscape, and can still retain that little bit of human dignity, bereft of which you reach the uttermost depths. The members of